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MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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Executive Director
MS Division of Medicaid

DOM to phase in Quality Incentive Payment Program (QIPP) for hospitals

In June the Mississippi Division of Medicaid (DOM) introduced the Quality Incentive Payment Program (QIPP), a new component of the Mississippi Hospital Access Program (MHAP), to comply with federal regulations. The goal of QIPP, which took effect with the start of state fiscal year (SFY) 2020, is to utilize state and federal funds to improve the quality of care and health status of the Mississippi Medicaid population.

In 2016, the Centers for Medicare and Medicaid Services (CMS) issued new regulations for all Medicaid managed care programs, which included a requirement that pass-through payments, such as DOM's MHAP, are fully phased out or that the payments transition to accountability-based models within 10 years. Consequently, DOM developed QIPP to begin linking MHAP payments – now referred to as the transitional payment pool (TPP) – to utilization, quality, or outcomes.

The QIPP will be a multi-year project with an increasing percentage of pass-through payments being transitioned to payments tied to performance improvements achieved and maintained by the hospital industry. QIPP funding will initially focus on improving potentially preventable readmission (PPR) rates.

Readmissions will be measured across all hospitals on a quarterly basis with the readmission being attributed to the original discharging hospital. The metric will exclude maternity and newborn readmissions. Also, the metric will include Emergency Department admits for a condition related to a recent hospital discharge. The readmission rate metric will include all clinically-related readmissions associated with a hospital discharge within the previous 15 days.

DOM will phase in QIPP over three years. For SFY 2020 the QIPP portion of the TPP will be 10 percent. To do this, we are working with hospitals to set a hospital-wide readmission rate threshold, as well as a targeted improvement percentage for hospitals with rates exceeding that threshold.

Hospitals received their first quarterly PPR reports in June with instructions to review and attest to receiving those reports within 30 days. During SFY 2020, each hospital should develop initiatives to improve its readmission rates based upon review of their quarterly PPR reports.

Hospitals that have completed the quarterly attestation submissions will be eligible for the full 10 percent QIPP payment. No payment in SFY 2020 will be linked to actual PPR performance.

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On an annual basis, DOM will establish an initial acceptable hospital-wide readmission rate threshold, as well as a targeted improvement percentage for hospitals with rates exceeding the threshold. The goal will be set as a percent improvement over each individual hospital's baseline performance. For hospitals with rates below the threshold, those hospitals must remain below the threshold. The actual to expected PPR measures will be adjusted for acuity and patient mix and made available by DOM.

While both DOM and hospitals will have to adapt to these changes, we believe this program fits into our overall focus on quality and getting the best value possible for Medicaid beneficiaries and taxpayers, which also aligns with CMS' priorities. QIPP will be a measurable way to ensure state and federal funding improves the quality of care and health status of the Mississippi Medicaid population.

DOM will share more details and information about QIPP as the program develops. In the meantime, please review any messages you receive from the QIPP@medicaid.ms.gov email address. You may also direct any questions you have to the same email address, QIPP@medicaid.ms.gov.

New CHIP contracts take effect Nov. 1, 2019

In other news, providers should be aware that DOM will implement the new contracts for the Children's Health Insurance Program (CHIP) on Nov. 1, 2019. These three-year contracts were procured in 2018 and take effect during this year's open enrollment period for both CHIP and MississippiCAN members, from Oct. 1 – Dec. 15, 2019.

CHIP will continue to be administered by two coordinated care organizations (CCOs), with one important change – Molina Healthcare will replace Magnolia Health as one of the two CCOs. UnitedHealthcare Community Plan will continue to serve as the other CCO. This only applies to CHIP; all three plans will continue to participate in MississippiCAN.

As always, DOM encourages providers to enroll in all Mississippi Medicaid programs and wants providers to be aware that Molina Healthcare will be providing CHIP services come Nov. 1, 2019. For more information, visit https://medicaid.ms.gov/programs/childrens-health-insurance-program-chip/.

WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal.** The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at www.ms-medicaid.com.

PHARMACY NEWS

Insulin Monthly Quantity Limits and Frequently Asked Questions (FAQs) Concerning Insulin Billing Policy

The new Insulin Pen Quantity Limit List can be found on DOM's website at https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/.

Insulin FAQs

1. **Are insulin pen boxes considered unbreakable?**
   Policy on this matter varies among pharmacy providers (stores). Therefore, the DOM pharmacy claims processing system rules allow boxes containing insulin pen refills/cartridges to be processed as either unbreakable OR breakable.

2. **DOM states that beneficiaries are limited to a maximum supply of 31 days. Does that mean if one (1) box of insulin (vials or cartridges) does not last the patient 31 days, then a second box can be submitted as one claim?**
   Yes, and the two (2) boxes dispensed should be submitted with the correct day supply for which they will last the beneficiary. That is, a days' supply over 31 days can be submitted on one prescription claim. For example, a prescription is written for Lantus and according to the directions, one box will only last the patient 20 days. The pharmacist is allowed to dispense two boxes and bill as a 40 days' supply.

3. **What happens in the case where the smallest package size (1 box of 5 insulin pen cartridges) is over 31 days? Does DOM require the pharmacy to break the box of pens and only give the patient the correct amount to get them under the 31 day allowance?**
   No, it is not required that the pharmacist only dispenses one single pen cartridge / break the box of pen cartridges. The key thing is to always bill the correct days' supply that the total quantity dispensed will last the patient according to the prescriber's directions found on the prescription.

   Pursuant to Administrative Code Title 23, Part 214, Rule 1.6: Prescription Requirements https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-214.pdf:

   "The Division of Medicaid requires that all drugs be prescribed in a full month's supply which may not exceed a thirty one (31) day supply. The following exceptions are allowed. . . Drug products where the only available package size of the product is one that exceeds the thirty one (31) day supply limit. . ."

   Insulin vials and pen cartridge boxes are considered to fall under the exceptions as stated in this section of Administrative Code.

New Recommendations for Initial Treatment of Asthma

In April 2019, the Global Initiative for Asthma (GINA) updated the Asthma Management and Prevention Report with the most important change in asthma management in over 30 years. GINA no longer recommends treatment with SABA alone. Previous recommendations for the initial treatment of mild asthma were with a short-acting beta2-agonist (SABA) inhaler only. The new report recommends that all adults and adolescents with asthma receive either symptom-driven (for mild asthma) or daily inhaled low-dose inhaled corticosteroid (ICS)-containing controller treatment to reduce their risk of serious exacerbations.

Reference:

Global Initiative for Asthma, 2019 Global Strategy for Asthma Management and Prevention Report. Available at: https://ginasthma.org/reports/.

Reminder – Correct Billing of 340B Drug Claims

On November 1, 2018, the Division of Medicaid (DOM) implemented 340B billing policy. Providers who bill 340B purchased drugs and have both enrolled as Covered Entities with Health Resources and Services Administration (HRSA) and have attested to opt-in with the state are reminded of the following important billing requirements.

Pharmacy Claims

The provider must submit the actual acquisition cost (AAC) in the ingredient cost field. This AAC is defined as the actual price paid to the wholesaler or manufacturer for the 340B drug with no mark-up.

The AAC must be submitted in field #4Ø9-D9, field name "INGREDIENT COST SUBMITTED". The professional dispensing fee must be submitted in field # 412-DC, field name "DISPENSING FEE SUBMITTED".

Many providers are billing a '05' rather than a '08' in Field 423-DN. Providers must enter the following values in this table.

Field	Value	Description
Submission Clarification Code (42Ø-DK)	2Ø	34ØB - Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 34ØB of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)).
Basis of Cost Determination (423-DN)	08	34ØB Disproportionate Share Pricing

Medical Claims

Providers billing on a CMS 1500 Health Insurance Claim Form or Uniform Billing (UB- 04) Form must enter a "UD" modifier to identify a 340B purchased drug in addition to the corresponding Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC).

HEDIS® QUICK TIPS Appropriate Use of Antibiotics:

- For children with complaints of a sore throat, please conduct a rapid strep test prior to prescribing antibiotics.
- Avoid prescribing antibiotics for children diagnosed with an upper respiratory infection as most are viral.
- Avoid prescribing antibiotics as a routine treatment for adults diagnosed with acute bronchitis.
- Educate patients on the difference between bacterial and viral infections.
- For patients insisting on an antibiotic:
  - Give a brief explanation
  - Write a prescription for symptom relief instead of an antibiotic
  - Encourage follow-up in 3 days if symptoms do not improve

By utilizing these tips, rates will increase for the following HEDIS® measures:

- Appropriate Testing for Children with Pharyngitis (CWP)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

Prevention and Screening:

- Breast Cancer Screening (BCS) Recommendations for ages 50-74
  - Mammogram every 2 years
  - Early detection gives women new treatment options
  - Document in chart the date of last mammogram
  - Document history of bilateral or unilateral mastectomy and date

- Cervical Cancer Screening (CCS) for ages 21-64
  - Cervical cytology every 3 years
  - Cervical cytology/human papillomavirus co-testing every 5 years for ages 30-64
  - Document in chart date of cervical cytology and result or finding
  - Document history of hysterectomy (complete, total, or radical) and date

- Chlamydia Screening in Women (CHL)
  - Chlamydia screening yearly for sexually active women ages 16-24
  - Urine test or cervical swab

- Colon Cancer Screening (COL) Recommendations for ages 50-75
  - Fecal Occult Blood Test (FOBT) every year
  - Fecal Immunochemical Test (FIT)-DNA every 3 years
  - Computed Tomography (CT) colonography or Flexible sigmoidoscopy every 5 years
  - Colonoscopy every 10 years
  - Document in chart procedure and date

PROVIDER COMPLIANCE

Hospital Inpatient APR-DRG Alert – July 1, 2019 Updates

The Mississippi Division of Medicaid (DOM) implemented the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2019:

The following APR-DRG parameters were updated:

a. Base Price – changed from $6,585 to $6,574
b. DRG Cost Outlier Threshold – changed from $45,000 to $47,000

Due to significant changes in the clinical logic and relative weights from version 35 to version 36 of the 3M APR-DRG grouper, DOM did not update to version 36 on July 1, 2019. The changes to the logic and weights in version 36 will have a substantial impact on hospital reimbursement; as a result DOM decided to remain on version 35 of the APR-DRG grouper and weights for an extra year in order to study how best to adapt to the new logic and weights. DOM will perform claims analyses using the version 37 grouper when it becomes available, to determine changes in APR-DRG parameters that will be necessary for the July 1, 2020 APR-DRG updates.

Please keep in mind that hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems have been updated to reflect the above-mentioned changes that occurred for hospital discharges beginning on and after July 1, 2019.

Ordering, Referring and Prescribing (ORP) Provider Revalidation

The Division of Medicaid has an anticipated implementation date of September 2019 for the revalidation of all Ordering, Referring and Prescribing (ORP) enrolled providers based on Federal Regulation 42 CFR §455.414 which requires state Medicaid agencies to revalidate the enrollment of all providers every five years.

A revalidation letter which initiates the process with each provider will be sent to the Mail Other Address for Provider Communications on file. The letter provides instructions for completing the revalidation and indicates the due date. As part of the revalidation, DOM must conduct a full screening appropriate to the provider's risk level in compliance with 42 CFR Part 455 Subparts B & E and the provider must comply with any requests made by the state as part of the revalidation process within the specified timeframe. A complete revalidation must be submitted by the due date in the letter to prevent termination.

Providers must access their revalidation electronically through the Envision web portal. This will allow providers to enter their own information and will streamline the revalidation process. If the revalidating provider is not a registered user, the provider must register by going to www.ms-medicaid.com and clicking the "web registration" link to find the registration instructions for becoming a web portal user.

A Six Month Revalidation Due List is located on the secure and nonsecure sides of the Envision web portal located at https://www.ms-medicaid.com. The list is housed under the Provider tab and will be updated weekly noting those providers who are due to be revalidated within the next six (6) months. If the mailing address noted is incorrect, providers are encouraged to submit the Change of Address form located at www.ms-medicaid.com. The form is housed under the Provider tab in the Forms submenu.

Enrollment will be terminated for any provider who does not comply with revalidation requirements. A new ORP application will then be required to re-enroll in the Mississippi Medicaid program.

Providers with questions or needing additional assistance concerning revalidation should contact Conduent at (800) 884-3222.

Attention Nursing Facilities

Effective October 1, 2019, CMS will retire the Medicare Prospective Payment Systems (PPS) 14-day, 30-day, 60-day, 90-day, and Medicare PPS unscheduled assessments. The Mississippi Division of Medicaid (DOM) will not require the submission of the Optional State Assessment (OSA) October 1, 2019.

Attention DME Providers – DOM Coverage of Incontinence Garments - UPDATE

Effective August 1, 2019, Mississippi Division of Medicaid (DOM) coverage of incontinence garments will include the following updates:

- HCPCS code T4525 - age range updated to 0 - 999
- HCPCS code T4544 - for all eligible beneficiaries and should be utilized for billing beginning with dates of service on or after 8/1/2019.
- HCPCS code T4543 - reimbursement will change from 'priced by prior authorization' to a reimbursement rate of $1.00 per unit.

HCPCS Code	Fee Effective August 1, 2019
T4543	$1.00
T4544	$1.00

Failure to obtain prior authorization of all incontinence garments will result in denial of payment. The updated Medical Supply fee schedule will be available on 8/1/2019 at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

As a reminder, DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. Failure to obtain prior authorization will result in denial of payment. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads.

Beneficiaries eligible for certain Home and Community Based Services (HCBS) waivers may receive additional units through those benefits, if medically necessary and prior approved. If applicable, DME providers would receive authorization to provide those additional units from waiver case managers.

Requirements for the Nurse Practitioner and Physician Assistant's Collaborating Physician

The Division of Medicaid requires the collaborating physician for a nurse practitioner or physician assistant to enroll as a (1) Mississippi ordering, referring or prescribing (ORP) provider or a (2) Mississippi Medicaid provider.

Fee-For-Service (Regular Medicaid) Claims Timely Filing

Effective July 1, 2019, all claims not paid by June 30, 2019 are subject to Miss. Admin. Code Part 200 Rule 1.6: Timely Filing, Rule 1.7: Timely Processing of Claims, and Rule 1.8: Administrative Review of Claims. These new rules can be viewed at https://medicaid.ms.gov/wp-content/uploads/2019/08/00024160b.pdf.

- Claims filed within three-hundred sixty-five (365) calendar days from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim and be received by the Division of Medicaid within three-hundred and sixty-five (365) days from the date of the submittal of the original claim.
- If a provider is unable to submit a claim within three-hundred sixty-five (365) days from the date of service due to retroactive beneficiary eligibility, claims must be submitted within sixty (60) days of the eligibility determination.
- Claims by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

Timely Filing- Medicare Crossover Claims

Medicare crossover claims for coinsurance and/or deductible must be filed with DOM within 180 days of the Medicare Paid Date.

- Providers may submit a corrected claim within 180 days of the Medicare paid date.
- Providers may request an Administrative Review within thirty (30) calendar days of a denied Medicare crossover claim once the 180 day timely filing has been expired.

Mass Adjustments

If the Division of Medicaid adjusts claims after the processing period has ended, providers may submit a written request for an Administrative Review within ninety (90) calendar days of the date of the remittance advice (RA). Providers must submit additional documentation to support claims payment.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within sixty (60) days of the beneficiary's eligibility determination,
- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or
- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,
- Documentation supporting the reason for the Administrative Review, and
- Other documentation as required or requested by the Division of Medicaid.
- Submit Administrative Reviews to:

  Division of Medicaid
  Attention: Office of Appeals
  550 High Street, Suite 1000
  Jackson, MS 39201
  Phone: 601-359-6050
  Fax: 601-359-9153

Timely Filing rules may be found on the Division of Medicaid website at www.medicaid.ms.gov (Administrative Code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8).

COORDINATED CARE NEWS

Molina Healthcare Appeals Quick Reference for Providers

Pre-Service Appeals

- For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals at (844) 808-2407.

Post-Service Appeals

- For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals at (844) 808-2409.

If a provider rendered services without getting an approved PA first, providers must submit the claim and wait for a decision on the claim first before submitting a dispute/appeal to Molina.

Molina Healthcare Member Resolution Team (MRT) and Provider Resolution Team (PRT) will continue working together to re-route any misdirected requests. However, participating providers sending disputes/appeal requests to the wrong department could delay response time.

Molina Healthcare Provider e-Newsletter

Molina Healthcare of Mississippi's Provider e-Newsletter is a great way for providers in Mississippi to receive helpful information, education, important updates and more! Our goal is to reach everyone in your organization, and you can help by sharing and recommending this newsletter to your colleagues and partners. It is a pleasure to partner with you and we encourage you to stay connected with us.

To subscribe to receive this quarterly newsletter by email visit https://www.molinahealthcare.com/providers/ms/medicaid/comm/Pages/newsletters.aspx.

Molina Healthcare Newborn Delivery Prior Authorization Process Update

In order to help streamline our Newborn Delivery Prior Authorization (PA) process, Molina Healthcare of Mississippi no longer requires that a PA form is filled out and sent to us for a "normal newborn delivery" (CPT codes 59410 and 59515). Molina will now follow similar practices conducted by the other Coordinated Care Organizations (CCOs) contracted with the Mississippi Division of Medicaid (DOM) by creating an authorization number using the Newborn Enrollment Form sent to DOM.

If the expected stay of the member should exceed the "normal" three-day stay for vaginal delivery or a five-day C-Section stay, then a Molina PA form must be completed online at https://Provider.MolinaHealthcare.com or faxed to Molina at **(844) 207-1622**.

We expect this small change to have a significant impact on provider workflow efficiency and Molina's timely response. If you have any questions regarding the change in process, please feel free to reach out to our Utilization Management Department at **(844) 826-4335**.

NICU Authorization Fax Transition Effective August 1, 2019

After examining our Neonatal Intensive-Care Unit (NICU) Model of Care for ways to better assist our members and providers, Molina Healthcare of Mississippi NICU Authorization fax will transition from a corporate fax number to Molina Healthcare of Mississippi fax number. Effective August 1, Providers should fax all NICU Authorization requests to **(844) 207-1622**.

The benefits of sending the NICU cases to the Health Plan's general inpatient fax number will allow the Health Plan to assign and delegate a local Utilization Management (UM) Nurse to the case based on the providers location, prioritize and adjust the number of reviewers as needed or based on the number of prior authorizations (PAs) received, and help foster a better working relationship while promoting two way communication to provide a better overall experience for both members and providers.

Molina Healthcare Primary Care Provider (PCP) Member Roster

As a PCP for Molina Healthcare of Mississippi, you have access to your Member Roster which is available on our secure provider portal. It is your responsibility to review your Member Roster frequently to identify new and current members. To register for the secure provider portal or to view your Member Roster, please follow the provided instructions below.

If you need additional assistance, please contact your Provider Services Representative

How to Register

1. Go to **https://Provider.MolinaHealthcare.com**.
2. Click on the "Register now" link under the Provider Web Portal Login box.
3. Under Admin User Responsibility, select "To continue with registration, click here" and you will be taken to the registration page.

How to Review Member Roster

1. Once you login to the Provider Portal, go to the Provider Portal Panel on the left hand side and select Member Roster.
2. The Member Roster application enables the registered user to view and navigate through a list of Members assigned to a Primary Care Provider (PCP).

You will be able to:

- Customize Member search with built-in filters and sorting functions.
- View various statuses (e.g. needed services, inpatient, new Members, etc.) for Members.
- Check Member eligibility.
- Easily access other functions to view Member details, submit claims and request service authorizations.

UnitedHealthcare® Community Plan

New Transportation Vendor for UnitedHealthcare Community Plan Members Beginning August 1, 2019

Starting August 1, 2019, Medical Transportation Management (MTM) replaced National MedTrans Network (MedTrans) as the transportation benefit provider for UnitedHealthcare Community Plan of Mississippi members. This includes MSCAN and Dual Eligible (DSNP). This means that members will need to contact MTM to schedule and arrange their non-emergency medical transportation.

No action is required from providers during the transition. Members began to receive information about MTM and scheduling their transportation beginning July 1, 2019. If you have staff who arrange transportation on behalf of a member, you may contact MTM directly at 844-525-3085.

This vendor change won't affect the member's transportation benefit or services. The only difference is the member will now contact MTM to arrange transportation. Members can call MTM directly or contact us at the Customer Service number on their ID card for help with using their transportation benefit.

If you have any questions, please contact Provider Services at **877-743-8734**. Thank you.

Update to MSCAN Enhanced PCP Reimbursement Effective July 1, 2019

In accordance with MS SPA 15-002, the Mississippi Division of Medicaid (DOM) has elected to reimburse for primary care services at one hundred percent (100%) of the Medicare Physician's Fee Schedule in effect as of January 1 of each year for physicians who meet the requirement of 42 CFR § 447.400(a).

The following provider specialties are eligible for the enhanced reimbursement:

- Provider Specialty Code 000 – General Practitioner
- Provider Specialty Code 004 – Pediatrician
- Provider Specialty Code 006 – OB / GYN
- Provider Specialty Code 012 – Internist
- Provider Specialty Code 031 – Family Practice

Eligible physicians must self-attest that they meet the following qualifications.

1) Specialty designation of family medicine, general internal medicine, obstetrics and gynecology (OB/GYN) and pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association, and
2) One of the following:
   i. Board certified in an eligible specialty or subspecialty, OR
   ii. 60% of total Medicaid paid codes for the previous calendar year was for the specific E&M and Vaccine Administration codes covered.

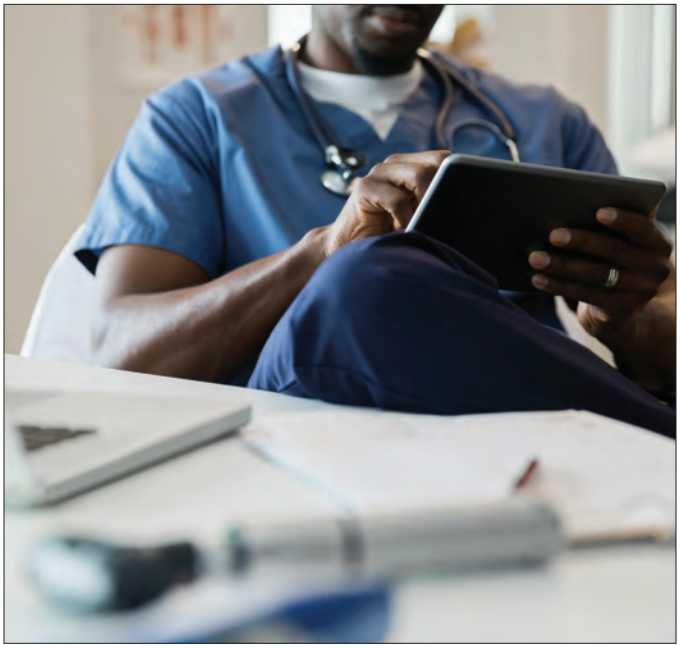
To the extent that these services (or their successors) are covered under MississippiCAN, the following primary care services are eligible for the enhanced payment:

- Evaluation and Management (E&M) Current Procedural Terminology (CPT) Codes 99201 through 99499.
- Vaccine administration Codes 90460 – 90461, 90465, and 90471 – 90474. The final rule also updates the interim regional maximum fees for vaccine administration provided under the Vaccines for Children (VFC) program.

UnitedHealthcare has historically paid these enhanced payments via accounts payable transactions to eligible practitioners outside of the claims processing system.

UnitedHealthcare will begin processing these enhanced primary care payments through the claim adjudication process beginning with July 1, 2019 date of service. Concurrent payment processes will be administered until the enhanced payments have been issued for all historical dates of service prior to July 1, 2019.

Additional information about the DOM Increased Primary Care Payment can be found here:
https://medicaid.ms.gov/qualified-providers-need-to-attest-re-attest-to-receive-increasedprimary-care-services-payments



MississippiCAN Home Health Update

In accordance with the Division of Medicaid Administrative Code changes to Part 215: Home Health Services, Chapter 1: Home Health Services, Rule 1.3: Covered Services effective **7/1/2019**, Home Health visit benefit limits will increase from **twenty-five (25) to thirty-six (36)** per year.

Provider Notification- Removal of Prior Authorization Requirement for E0618 and E0619 Apnea Monitor

Effective **April 8, 2019** MississippiCAN members 1 year old and under will not require authorization for **E0618** and **E0619** Apnea Monitor for any providers. All other Magnolia MississippiCAN and Magnolia CHIP members will require authorization for all providers.

Provider Notification of Updated Prior Authorization Requirements Effective 7/1/19 - MississippiCAN

In an attempt to best serve our members to ensure they receive the most appropriate care, Magnolia Health (MississippiCAN) will require PA for ALL providers for the following codes effective **7/1/2019**:

J9042
J9271
J9299
J9306

*Please note, previously these codes required PA for all providers except Hematology and Oncology providers.

Provider Notification - Removal of Prior Authorization Requirements (Magnolia MississippiCAN Only)

In an attempt to better serve our Magnolia members and ease provider administrative burden, effective **4/8/2019** Magnolia Health will no longer require prior authorization for Physical Therapy/Occupational Therapy/Speech Therapy **(PT/OT/ST)** codes for **MississippiCAN** members age 12 and under. All Magnolia Children's Health Insurance Program (CHIP) members **will** require Prior Authorization for PT/OT/ST services.

In accordance with the Administrative Code Title 23 Part 300, providers must ensure that the services rendered are provided economically and are medically necessary, of a quality that meets professionally recognized standards of health care, and supported by the appropriate documentation of medical necessity and quality. If it is identified by data analysis or other means that a possible violation of one of these obligations has occurred, a post-payment audit may occur. Magnolia Health Plan representatives will contact the provider prior to the post payment audit with information as to the reason for the audit and follow up with the provider on a corrective action plan if needed.

Magnolia Health Updated Payment Policies Effective 5/1/19 - All Products

We are happy to inform you that Magnolia Health is publishing its Payment Policies to inform providers about acceptable billing practices and reimbursement methodologies for certain procedures and services. Magnolia Health Plan believes that publishing this information will help providers to bill claims more accurately, therefore reducing unnecessary denials and delays in claims processing and payments.

We will apply these policies as medical claims reimbursement edits within our claims adjudication system. This is in addition to all other reimbursement processes that Magnolia Health Plan currently employs.

These policies are developed based on medical literature and research, industry standards and guidelines as published and defined by the American Medical Association's Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society guidance, unless specifically addressed in the fee-for-service provider manual published by the state of Mississippi or regulations.

Visit https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html to find the Payment Policies. The effective date for the below policies is 5/1/19.

- CC.PP.060 – Not Medically Necessary Inpatient Services
- CC.PP.061–Non-obstetrical Pelvic and Transvaginal Ultrasounds
- CC.MP.161 – Monitored Anesthesia Care for Gastrointestinal Endoscopy
- CC.PP.063 – Place of Service Mismatch
- CP.MP.100 – Allergy Testing and Therapy.

Updated Prior Authorization List - Effective 8/1/2019

Attention Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) Providers:
Updated Prior Authorization Lists effective 8/1/2019 have been posted to the Magnolia website.

Click the links below to view:

MississippiCAN Prior Authorization List
CHIP Prior Authorization List

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

MississippiCAN and CHIP Provider Survey

Name: _____ **Facility:** _____ **Phone:**_____

We need your help to tell us how well the MississippiCAN and CHIP programs are performing. Please take a few minutes to complete this survey by placing a checkmark beside your response. If you have any questions, please contact the Office of Coordinated Care (601) 359-3789. Please forward Provider Satisfaction surveys to: MississippiCAN.Quality@medicaid.ms.gov

1. Describe your overall experience with the MississippiCAN/CHIP program?
   ☐ Good ☐ Fair ☐ Poor
2. Which MississippiCAN network are you enrolled?
   ☐ Magnolia ☐ United ☐ Molina ☐ All
3. Which CHIP network are you enrolled?
   ☐ Magnolia ☐ United ☐ Molina ☐ All
4. How often do you receive notification of changes from the health plans?
   ☐ Monthly ☐ Quarterly ☐ Annually
5. How often do you check eligibility for your patients?
   ☐ Daily ☐ Weekly ☐ Monthly ☐ At time of visit
6. Do you utilize the Health plans' web portal?
   ☐ Yes ☐ No
7. Do you receive a member roster panel from the Health plans?
   ☐ Yes ☐ No
8. Do you know your provider representative with the health plans and does your provider representative visit your facility?
   ☐ Yes ☐ No
9. Have you seen improvement in the quality of care with the Mississippi beneficiaries?
   ☐ Improved ☐ Somewhat Improved ☐ Not Improved
10. Claims are processed in a timely manner. ☐ Agree ☐ Disagree
11. Claims' inquiries are answered promptly by the Health plan. ☐ Agree ☐ Disagree
12. The Health Plan's PA process works efficiently. ☐ Agree ☐ Disagree
13. Denial notifications provide clearly defined denial reasons. ☐ Agree ☐ Disagree
14. Claims are paid at the correct rates (no less than Medicaid's). ☐ Agree ☐ Disagree
15. Provider Grievance & Appeals process is effective. ☐ Agree ☐ Disagree
16. My facility is familiar with & refers patients to the CCO's Disease & Care Management programs. ☐ Agree ☐ Disagree
17. My facility is aware of and utilizes Health Plan's Case Management services. ☐ Agree ☐ Disagree
18. The provider workshops are beneficial for my type of practice. ☐ Agree ☐ Disagree

If you disagreed with any of the questions above, please provide your comments for improvement.

Comments: _____

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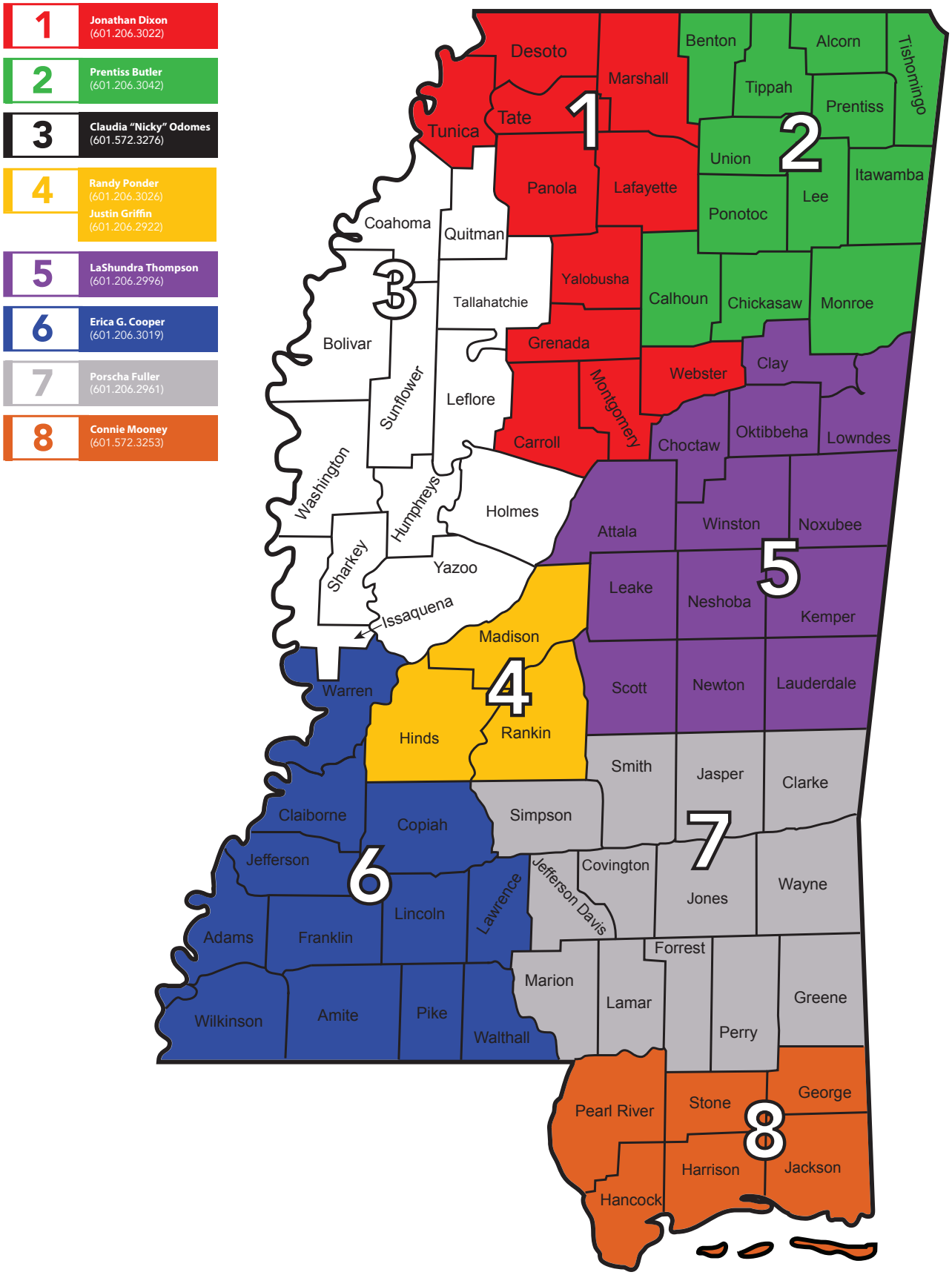
FIELD REPRESENTATIVE REGIONAL MAP



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Jonathan Dixon (601.206.3022)** jonathan.dixon@conduent.com	**AREA 2** **Prentiss Butler (601.206.3042)** prentiss.butler@conduent.com	**AREA 3** **Claudia "Nicky" Odomes (601.572.3276)** claudia.odomes@conduent.com
County	**County**	**County**
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
***Memphis**		
AREA 4 **Justin Griffin (601.206.2922)** justin.griffin@conduent.com **Randy Ponder (601.206.3026)** randy.ponder@conduent.com	**AREA 5** **LaShundra Thompson (601.206.2996)** lashundra.othello@conduent.com	**AREA 6** **Erica G. Cooper (601.206.3019)** ERICA.Cooper@conduent.com
County	**County**	**County**
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	
AREA 7 **Porscha Fuller (601.206.2961)** porscha.fuller@conduent.com		**AREA 8** **Connie Mooney (601.572.3253)** connie.mooney@conduent.com
County		**County**
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		**Slidell, LA**
Forrest		**Mobile, AL**
Perry		
Greene		
Wayne		
Clarke		
OUT OF STATE PROVIDERS	**Latasha Ford (601) 572-3298** Latasha.Ford@conduent.com	

CONDUENT
P.O. BOX 23078
JACKSON, MS 39225

If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web
www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal
www.ms-medicaid.com

SEPTEMBER 2019

MON, SEPT 2	Labor Day DOM Closed
THURS, SEPT 5	EDI Cut Off - 5:00 p.m.
MON, SEPT 9	Checkwrite
THURS, SEPT 12	EDI Cut Off - 5:00 p.m.
MON, SEPT 16	Checkwrite
THURS, SEPT 19	EDI Cut Off - 5:00 p.m.
MON, SEPT 23	Checkwrite
THURS, SEPT 26	EDI Cut Off - 5:00 p.m.
MON, SEPT 30	Checkwrite

OCTOBER 2019

THURS, OCT 3	EDI Cut Off – 5:00 p.m.
MON, OCT 7	Checkwrite
THURS, OCT 10	EDI Cut Off – 5:00 p.m.
MON, OCT 14	Checkwrite
THURS, OCT 17	EDI Cut Off – 5:00 p.m.
MON, OCT 21	Checkwrite
THURS, OCT 28	EDI Cut Off – 5:00 p.m.
MON, OCT 31	Checkwrite

NOVEMBER 2019

MON, NOV 4	Checkwrite
THURS, NOV 7	EDI Cut Off – 5:00 p.m.
MON, NOV 11	Veteran's Day DOM Closed
THURS, NOV 14	EDI Cut Off – 5:00 p.m.
MON, NOV 18	Checkwrite
THURS, NOV 21	EDI Cut Off – 5:00 p.m.
MON, NOV 25	Checkwrite
THURS, NOV 28- FRI, NOV 29	Thanksgiving DOM Closed

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.